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Children's Mental Health in New Hampshire: Evidenced Based Practice

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About this paper

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Children's Mental Health in NH: Evidence Based Practice

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Executive Summary

Mental health disorders have far-reaching implications for the children affected with them. Mental health issues can impact a child's emotional, intellectual, and behavioral development. It can hinder proper family and social relationships. And, mental health disorders, if left untreated, can persist through development and into adulthood.

Children with mental health problems are less likely to succeed in school, are absent more days from school, and have suspension and expulsion rates that are three times as high as their peers. As many as 44% of high school youth with mental illness eventually drop out of school.[1] Children with mental illness are more likely to be involved with the child welfare system and the criminal justice system. In the child welfare system, half of children have mental health needs.[2] And, in the juvenile justice system, 67-70% of youth have a mental health problem.[3]

Treatment for mental illnesses can be highly effective. With appropriate effective services tailored to a child's needs, most children can reduce the impact of their illness and avoid future developmental, social, and behavioral problems. Evidence-based practices are treatments and services empirically shown to produce positive outcomes.

This summary reviews the scope of evidence-based practices (EBPs) for the treatment of mental illness in children in New Hampshire. A more technical and in-depth discussion of EBPs can be found in the report that follows. This paper will describe current knowledge about EBPs and discuss current use and integration into the public mental healthcare system. The research draws from the national literature on EBPs, interviews with state and national experts, and a survey of the children's directors from the State's Community Mental Health Centers (CMHCs).

Evidence Based-Practices

Simply put, evidence-based practices are services or therapies that show positive outcomes for recipients as determined by strong scientific research evidence[4] and are also consistent with a set of core values for mental health services.

The most robust EBPs are those that have been studied in a randomized-controlled trial – a type of study that is similar to testing a drug against a placebo – and have been evaluated in a practice setting. Furthermore, EBPs must be administered with fidelity. That is, each recipient must receive a similar service and the service delivered must adhere to the primary

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[1] M Wagner. "Youth with disabilities leaving secondary school." *Changes Over Time in the Early Post School Outcomes of Youth with Disabilities: A Report of Findings from the National Longitudinal Transition Study (NTLS) and the National Longitudinal Transition Study-2 (NTLS2)*. Menlo Park, CA: SRI International. 2005.

[2] B Burns, S Phillips, H Wagner, R Barth, D Kolko, et al. "Mental health need and access to mental health services by youths involved with child welfare: A national survey." *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8);960-970. 2004.

[3] KR Skowyra and JJ Cocozza. "Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system." The National Center for Mental Health and Juvenile Justice and Policy Research Associates, Inc. 2006.

[4] Therapies that have not been scientifically validated - but fill in gaps in services and have shown promise – are considered to have "practice-based" evidence, and are not EBPs.

methods of intervention over time. Given that mental health services are person-to-person, it is essential that EBPs are "manualized" and use standardized assessment tools to ensure the consistency of care.

Beyond the scientific evidence, evidence-based practices must adhere to a core set of values. New Hampshire's public mental health system has adopted six principles for mental health services. EBPs shoud be: 1) Child-centered – to meet individual needs; 2) Family-focused – to engage the parents as partners in treatment; 3) Community-based – to access services and agencies beyond the mental health professionals; 4) Multi-system – to coordinate all agencies involved in a child's life; 5) Culturally competent – to respect peoples' beliefs and values; 6) Least restrictive – to provide services in the most suitable setting for the child and family.

Currently, there are 40-50 practices that meet the criteria for being evidence-based.[5] Two of the most widely embraced EBPs are Cognitive Behavioral Therapies (CBTs) - with distinct components for depression, trauma, and anxiety disorders - and various parent management approaches typically involving support, education, and therapy. Due in large part to the work of the Dartmouth Trauma Intervention Research Center, trauma-focused CBT (TF CBT) is the most widely implemented approach within New Hampshire's public mental health system.

Evidence Based-Practices in New Hampshire

To evaluate the current state of EBP integration in the mental health system we conducted interviews with a variety of policy-makers as well as surveyed the CMHC's children's services directors.

Results point to increasing activity, support, and anticipation for evidence-based practice in New Hampshire, evident in a number of initiatives. However, results also indicate there is some tension around any movement toward evidence-based practices, particularly if these shifts require loss of current practice-based methods, which may not have the research foundation required by EBPs but may meet gaps in services.

In addition, several organizational infrastructures may be developing to support the dissemination of EBPs, connect key stakeholders at the state and local levels, and address the administrative, funding, policy, and legislative issues that are prerequisite to implementing and sustaining EBPs. What follows is a brief discussion of the organizations leading the public sector efforts.

1. The Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention and Research Center

The Dartmouth Psychiatric Research Center (PRC) was established in 1985 as a state-funded collaboration between Dartmouth Medical School and the NH Division of Mental Health and Developmental Services. The PRC is nationally recognized for its work in evidence-based practice for adults with severe mental illness and has facilitated the implementation of EBPs in public mental health systems across the country.

[5] (Burns, telephone interview, 2007)

Utilizing a public health perspective, the DTIRC's primary objective is to increase the availability and effectiveness of evidence-based mental health care for currently un-served or under-served trauma survivors across multiple healthcare settings, including children exposed to trauma.

As a result of collaboration between these organizations, the New Hampshire Project for Adolescent Trauma Treatment (PATT) is implementing and evaluating best practices for trauma-exposed, severely emotionally disturbed adolescents served by New Hampshire's community mental health system. The project is piloting two EBPs serving 500 to 600 adolescents each year with a severe emotional disturbance. The project is also working to establish TF-CBT as a routine evidence-based practice in New Hampshire's CMHCs.

Futhermore, these organizations are developing a tele-health video conferencing infrastructure to assure that all regions of the state have ongoing access to expert training, supervision and consultation. With a tele-health infrastructure in place, all mental health centers will be better able to access a broader range of expert training, supervision, and consultation for other EBPs, psychiatry, and other practices.

2. New Hampshire Community Mental Health Centers

New Hampshire's ten community mental health centers provide state-supported services to treat mental illness. Largely funded through Medicaid fee-for-service funds, the CMHCs are independent non-profit organizations working via contractual relationships with the State.

The children's services directors of each CMHC were surveyed regarding evidence-based practices in their agency. Eight of the ten agencies responded to the survey – the CMHCs in Manchester and Derry did not respond.

In general, most were receptive to the concept of evidence-based practices and increasing EBPs within their agencies, identifying a variety of strengths that would support their development. These strengths included agency and executive support for EBPs, experience in implementation of EBPs for adults, excellent collaborative relationships with other agencies, and teleconferencing capability for supervision and training.

However, four primary concerns were raised.

1. That EBPs as manualized practices were of less value than the "practice-based evidence" services currently provided by highly qualified and trained clinicians.
2. Whether there was sufficient state-level commitment to funding and to the policy changes necessary to sustain new practices.
3. That training and resources for on-going supervision are too much of a burden and that time in training to practice EBPs would lose revenues.
4. That EBPs rigorous protocols would not achieve a positive-cost benefit for clinicians' time.

3. The Children's IROS/EBP Steering Committee

Under the auspices of the State Bureau of Behavioral Health, the IROS/EBP team's mission is to guide practice and policy decisions to improve children's mental health services.

The IROS/EBP team has been researching the various EBPs and implementation processes in other states and is also addressing the workforce development issues by providing staff training modules for the CMHCs. Furthermore, the Committee has also identified priority areas for further EBP dissemination. As with the trauma-focused work currently underway, Dartmouth will develop the treatment protocols, provide training, and measure practice fidelity.

4. The NH Division of Children, Youth and Families (DCYF)

DCYF provides foster care and residential placement services to over 1,400 children annually, through court intervention for abuse, neglect, delinquency or CHINS (child in need of services) petitions. Among the several levels of foster care provided, therapeutic foster care most closely approximates the evidenced-based practice of Treatment Foster Care.

Interviews with DCYF staff indicate that the agency hopes to integrate services for high-need, multi-agency children's care. Although currently in the initial planning stages, the agency hopes to pilot a single portal of access, combined with braided funding, to serve this population and their families. While the costs associated with treating this population are high, the goal of the effort is to provide services that result in better outcomes, not merely to save funds.

5. The New Hampshire Center for Effective Behavioral Interventions and Supports (NH-CEBIS)

NH-CEBIS is part of a multi-agency initiative to create a statewide infrastructure for training and collaboration between schools, parents, mental health, and community-based organizations. This program is designed to increase and enhance access to appropriate mental health services to children with the most significant needs with community-based infrastructures for the early identification, assessment, and provision of mental health services to children.

NH-CEBIS has enrolled and provided training and technical support to 5 school cohorts, comprising a total of 140 pre-schools, elementary, middle and high schools. The NH-CEBIS team is just beginning to train schools to adopt a practice that has positive evidence using single-subject research designs.

6. The New Hampshire Chapter of National Alliance on Mental Illness (NAMI NH)

NAMI NH advocates for the expansion of EBPs and views its role as educating families to expect appropriate, evidence-based services.[6]

[6] (Cohen, Ferber interview, July 2007).

Evidence Based Practices in School Settings

Psychosocial EBPs in school settings are a significant development in the field of serving children and youth with mental health problems. Many children needing mental health services - 70-80% - receive those services in school.[7]

Research has shown that a caring environment, consistency of implementation, high academic expectations, flexibility of services and academic programs, and developmentally appropriate services contribute to better school outcomes for all children, and yet the research on effective school-based mental health services is limited.[8]

Implementing EBPs across NH

Despite the increasing activity around EBPs, further expansion system-wide faces a number of barriers. Successful implementation requires that the key stakeholders have reached consensus on adopting radically new approaches to services. A concern is that there may not be consensus among the primary providers of mental health services to children in New Hampshire, especially surrounding any changes of "practice-based" services. Furthermore, the number of EBPs is growing and decisions regarding which ones to implement – and invest resources in – will require further buy-in.

Beyond providing information on evidenced-based practices and training staff, a long term approach addressing organizational development is required. Research has shown that proper staff selection, continued training and coaching, program evaluation, and sufficient administrative supports are all crucial components to successful implementation.

Moreover, a frequently cited barrier is reimbursement. The Bureau of Behavioral Health reports that it has linked its EBPs for adults to specific billing codes for most practices. Trauma-focused Cognitive Behavioral Therapy for adolescents is billed through existing treatment codes. While the administrative activities - training, data collection and supervision – that are associated with EBPs are not reimbursed.

Discussion Notes

The portfolio of evidence-based practices is just beginning to grow in New Hampshire. Currently, within the three primary public systems of care – the schools, the system for abused and neglected children, and the community mental health centers – EBPs are limited, though there is increasing activity and support. Many of these initiatives are not currently sustained through state funding. Also, local schools' efforts at implementing EBPs remain very limited, but could be a significant factor in determining how and where to implement new practices.

Since so many of the NH efforts are in the initial implementation stages, and because the few EBPs currently in place are targeted to only a small portion of the population receiving services, EBPs touch only a fraction of the children served throughout the state.

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[7] Burns et al. (1995)

[8] (Ringeisen, Henderson, & Hoagwood, 2003; Rones & Hoagwood, 2000)

Of note, these analyses primarily address public sector activities including mental health system and public school efforts. To the extent that private providers are utilizing EBPs is unknown and should be considered given that many children access private mental healthcare services.

Overall, the research shows that EBPs work across diverse populations, including persons in low-income families, and families of color. There are also an ever-expanding number of practices for children that are evidence-based. Stakeholders have indicated a general support for EBPs and have also identified significant resources to build on, including the efforts at Dartmouth, the CMHCs, and specific statewide efforts showing promise.

Despite these strengths, a number of concerns were expressed. Nearly all the community mental health centers, the family advocates, and other interviewees expressed concern that, unless mechanisms were established to maintain training, consultation, and to address reimbursement policies allowing for reimbursement of EBP activities, EBPs are not sustainable. In addition, the most significant impediment to implementation of EBPs was in human resources, particularly resources for training and consultation to maintain practice fidelity.

For the system as a whole, there are both system-wide and organizational supports that would be necessary to support the expansion of EBPs. At the system level, the keys for a successful and ongoing implementation of an EBP-focused system include consensus development on the direction the system is heading. At the organizational level, providing organizations with EBP expertise, sufficient training opportunities for staff, and creating funding, reimbursement schedules, and regulations that support EBPs are critical. Overall, as expressed by interviewees, there is a need to educate top level policy makers, legislative leadership, families, and consumers in order to build the demand for EBPs.

Introduction

This report is part of an investigation designed to inform the current knowledge base regarding evidence-based practices (EBPs) both nationally and in NH, the current status of EBP implementation in the state, and areas policy makers might consider as it supports improvements in access to EBPs in mental health services for New Hampshire children and adolescents. National literature on best practices and interviews with national and regional mental health experts serve as the basis for this report.

The report begins with a brief overview of EBPs and implementation, and offers a conceptual framework for assessing the status of EBP efforts in New Hampshire. The report also briefly describes current local and statewide initiatives or activities that may offer a basis for EBP implementation, and finally it summarizes themes, strengths, barriers and recommendations for moving forward with an EBP agenda.

Summary of Major Findings

The portfolio of evidence-based practices is just beginning to grow nationally and in New Hampshire. Consensus appears to be emerging around 40-50 practices which meet the standards of analytic precision necessary to qualify it as an evidence-based practice. Two of these EBPs appear to be Cognitive Behavioral Therapies (CBTs), with distinct components for depression, trauma, and anxiety disorders; and various parent management approaches typically involving support, education, and therapy.

Within the three primary public systems of care – the schools, the system for abused and neglected children, and the community mental health centers – EBPs are limited, though there is increasing activity and support. At the state level, the Bureau of Behavioral Health has begun to build a platform of evidenced-based practice using CBTs. The Division for Children, Youth and Families – the agency responsible for foster care services and abused and neglected children – has implemented therapeutic foster care which closely approximates an EBP model. Dartmouth Trauma Interventions Research Center (DTIRC) has pioneered evidence-based trauma services for children in partnership with West Central Services and the DHHS Bureau of Behavioral Health through the Partners for Adolescent Trauma Treatment (PATT) Project funded by the National Child Traumatic Stress Network. There are also significant activities at the local level. A number of Community Mental Health Centers have begun to explore the use of different evidence-based practices based on the needs of the community. Local schools' efforts at implementing EBPs remain very limited.

Despite the increasing activity around EBPs, further expansion in their implementation faces a number of barriers, according to various policymakers. A frequently cited barrier to implementation of these EBPs is reimbursement. The Bureau of Behavioral Health reports that it has linked its EBPs for adults to specific billing codes for most practices. Trauma-focused Cognitive Behavioral Therapy for adolescents is billed through existing treatment codes. While the administrative supports (training, data collection and supervision) are in place for trauma focused cognitive behavioral therapy (TFCBT) through the PATT Project they are not currently funded/sustained through state funds. The implementation of EBPs represents a sea-change in the mental health community and both consensus

development among policy makers, administrative supports and changes in reimbursement methodologies will be necessary in order to facilitate their expansion.

Data, Methods and Limitations

This analysis is informed by a variety of different sources of data. First, we conducted a brief review of the literature on evidence-based practices in child and adolescent mental health. Selection of literature was guided by consultation from experts in the field, particularly by Dr. Barbara Burns from Duke University Medical School. Second, we conducted personal and telephone interviews with over twenty state and national experts in EBPs, interviews with key informants at the NH Department of Health and Human Services, child and family-serving organizations, schools, and community mental health administrators and clinicians. For a full list of participants, please see Appendix A. Finally, we conducted a survey of the children's directors from the state's ten community mental health centers to assess the current state of EBP implementation and gauge the opportunities, context, and barriers from the point of view of the public community mental health system (see Appendix B).

Study Limitations

This study has a number of limitations. First, this analysis primarily addresses public sector activities including mental health system and public school efforts. The activities of private sector providers were beyond the scope and time constraints of this report. While it was impossible to interview all possible stakeholders in the mental health and public system, we are confident that we have heard from enough individuals to accurately describe issues and themes relative to EBPs in New Hampshire.

Second, this report does not provide an all-inclusive list of evidence-based practices. There are several such lists available, and we have provided several of these as Appendices. There is not universal agreement about what is and what is not an inclusive list of evidence-based practices for children. There seems to be some consensus among national experts that there are currently around 40-50 EBPs for children and adolescents.[9]

Third, we did not examine each diagnostic group of children. All lists of EBPs attempt to specify which diagnoses or problems an EBP is intended to treat and EBPs include screening protocols to ensure that treatment is delivered to those for whom the practice has been determined to be helpful.

Fourth, we did not survey school districts and so this report does include information about the extent of EBP implementation and service levels provided to children in and by schools. We do, however, include information about efforts to link the services of community mental health centers with schools, and school-based mental health interventions.

Finally, it was not within the scope of our task to assess the quality of EBP services provided, nor to quantify the numbers of children being served with EBPs. Since so many of the NH efforts are in the initial implementation stages, and because the few EBPs currently in place

[9] (Burns, telephone interview, 2007)

are targeted to only a small portion of the population receiving services, it is safe to say that EBPs touch only a fraction of the children and adolescents served throughout the state.

An Overview of Evidence-Based Practices

What Are Evidence-based Practices?

Simply put, evidence-based practices (EBPs) are services or practices which show positive outcomes for recipients as determined by strong scientific research evidence and are also consistent with a set of core values.

Hoagwood, Burns, & Weisz define evidence-based practices in children's mental health as:

> "a body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risks for mental disorders; or about the effects of treatments or services on mental health problems. It is a short-hand term denoting the quality, robustness, and validity of the scientific evidence that can be brought to bear on questions of etiology, distribution, or risk for disorders, and outcomes of care for children with mental health problems. "[10]

EBPs and CASSP Values

As with all mental health services, EBPs must also adhere to core values. In New Hampshire, these values have been promoted by the Child and Adolescent Service System Program (CASSP) initiative. CASSP, launched in 1984 by the National Institute for Mental Health, has provided a framework serving children with mental health needs, in part as a response to the work of Jane Knitzer and colleagues (1982). In New Hampshire, the NH Division of Behavioral Health received a multi-year CASSP grant to develop and improve its "system of care."

Perhaps the most significant result of the CASSP initiative has been the promotion of the concept of a "system of care", defined by Stroul and Friedman (1986) as: "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families."

New Hampshire's public mental health system, through the CASSP initiative, has adopted six principles for mental health services:

1. **Child-centered**: Service planning meets the individual needs of the child, rather than fits the child into an existing service.
2. **Family focused**: Services recognize the family is the primary support for the child. The family joins in as a full partner in all stages of the decision-making and treatment planning.
3. **Community-based:** Whenever possible, service delivery is in the child's home community, drawing on formal and informal help to promote the child's successful

[10] Hoagwood, Burns, & Weisz (2002) (p. 329)

participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

4. **Multi-system**: All the child-serving agencies involved in the child's life collaborate.
5. **Culturally competent**: The people providing services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.
6. **Least restrictive**: Service settings are the most suitable and natural for the child and family. These settings are the least restrictive and intrusive available to meet the needs of the child and family.

These values are similar to the common features of all evidence-based practices noted by Rapp and Goscha when describing EBPs for adults with serious mental illness. These factors are "(1) a focus on recovery and strengths (2) consumer empowerment and choice (3) recognizing meaningful relationships and how important they are to recovery (4) using the environment as a resource rather than viewing it as in impediment, and 5) teamwork and integration of helping." [11]

What Is Evidence?

What is the scientific evidence that defines a practice as being evidence-based? The highest standard – the "gold standard"- for evidence-based services is a service or intervention that has undergone multiple "randomized controlled" studies (RCT) by independent researchers that is published in peer-reviewed journals. The RCT method randomly assigns participants to either a group that receives the service or to a "control" group. The control group may receive another service or no service at all. The study then precisely measures the resulting change in the group that received treatment compared with the control group.

An increasing number of practices have been examined using randomized controlled studies but certainly not the entire universe of services that appear to be "promising." Nevertheless it is essential to understand that a so-called "promising" practice (also know by some as "practice-based evidence") is <u>not</u> an evidence-based practice.

It is also important to recognize that even when studies employ rigorous scientific methods, differences between controlled clinical environments and real world practice settings, cultural differences among consumers, and differences among staff providers may cloud or limit the results.[12]

Thus some operational definitions of evidence-based practice may accept fewer RCTs or substitute more studies that are less rigorously controlled, or combinations of both. The five levels defined by the State of Oregon, in its initiative to implement EBPs throughout its mental health and substance abuse services system, may be useful because they were developed with the broad input of clinicians, family members, consumers, administrators, and researchers. These definitions provide a brief look at the degree to which a service is evidence-based and the three different levels of evidence acceptable to meet this definition;

[11] Rapp and Goscha (2005) (p193).
[12] (Drake, Merrens, & Lynde, 2005, p. 51)

or is a "promising practice" with positive outcome data; or, at the farthest end of the spectrum, is a "customary" practice for which no evidence of effectiveness exists.[13] Oregon's levels of evidence-based practice include:

Level I. The service is grounded in consistent scientific evidence via randomized controlled studies showing consistently improved outcomes in both clinically controlled and real world settings. The service is standardized and documented to allow both replication and measurement of fidelity with a fidelity tool that defines the essential elements of the practice.
Level II. A service that is sufficiently documented through randomized controlled studies or rigorously conducted and designed evaluations but not necessarily in both a controlled setting and a routine care setting. The elements of the practice are standardized and demonstrated to be replicable and effective within given settings and for particular populations, so implementation can be measured with a fidelity tool or some other means, such as a quality review based on a manual defining the practice's essential elements.
Level III. A practice or prevention service based on elements drawn from Level I or II practices. The practice has been modified or adapted for a population or setting that is different from the one in which it was formally developed and documented. Based on the results of the outcomes, elements of the service are continually adapted or modified to achieve outcomes similar to those derived from the original practice. Practices difficult to study in rigorously controlled studies for cultural and/or other practical reasons but have been standardized, replicated, and achieved consistent positive outcomes will also be considered for Level III. Given these conditions, research published in an appropriate peer reviewed journal is still required.

Non Evidence-Based Practice Levels:
Level IV. A treatment or prevention service or practice not yet sufficiently documented and/or replicated through scientifically sound research procedures. However, the practice is building evidence through documentation of procedures and outcomes, and it fills a gap in the service system. The practice is not yet sufficiently researched to develop a fidelity tool.
Level V. A treatment or prevention service based solely on clinical opinion and/or non-controlled studies without comparison groups. Such a service has not produced a standardized set of procedures or elements that allow for replication of the service. The service has not produced consistently positive measured outcomes.

Further, to be evidence-based the service or intervention must be precisely defined and performed with "fidelity." That is, each recipient must receive a similar service and the service delivered must adhere to the primary methods of intervention over time. While this is more straightforward when studying the affect of a pill versus a placebo, real world person-to-person psychosocial interventions may result in differences among individual staff or among programs, resulting in loose adoption of the intervention. It is therefore essential that an evidence-based practice be "manualized" and incorporate rigorous training and supervision and ongoing consultation to standardize the intervention. Valid and reliable measures are also required to measure the "fidelity" of the intervention to the original model to avoid so-called "model drift."

[13] (Oregon, June 2006).

Evidence-based studies must also define the population served, by factors such as age, diagnosis, presenting problems, culture, and ethnicity. For example, an intervention or service that might work for a 10-year old child with clinical depression might be ineffective or even harmful for a 17-year old with a similar diagnosis. Or an evidence-based intervention for an adolescent with severe anxiety may not be indicated for an adolescent with severe substance abuse problems. Therefore, lists of EBPs must also include sufficient information to indicate who the practice is suited for in terms of age, presenting problem, diagnosis, behavior, or other well-defined factors.

Context of the EBP is also important. Many of the most promising EBPs appear to be those that incorporate a psychosocial approach to the child or a practical educational management approach to assist parents. These approaches are often a departure from the traditional clinic-based services and intervene with the child and family in the home or school.

What Practices Are Evidence-Based?

While the exact number of EBPs varies based on who is assessing EBPs, the standards employed in assessing the practice, and the particular population being assessed, there presently appear to be 40-50 practices that meet the criteria for being evidence-based.[14]

Several national efforts are underway to develop inventories of evidence-based services. One listing is the April, 2006 Matrix of Children's Evidence-Based Interventions published by the National Association of State Mental Health Program Directors (NASMHPD) (Appendix C)[15]. This document used multiple sources to develop a grid describing the disorders or problems treated, the research methods used to determine outcomes, the population served by the intervention, the availability of toolkits, manuals, or similar technical assistance materials, and the source of the information. The resulting Matrix of Children's Evidence-based Interventions provides an overview of the variety of service interventions and settings which claim to be evidence-based, although not all may adhere to the "gold standard" of scientific study corresponding to Level I evidence. (Appendix D)

Another site which describes evidence-based practices is The Society of Clinical Child and Adolescent Psychology of the American Psychological Association and the Network on Youth Mental Health. This web-based document is supported by the MacArthur Foundation and is updated to include evidence-based practices in children's mental health for Anxiety Disorders, Depression (Dysthymia), Attention Deficit Hyperactivity Disorder (ADHD)Conduct/Oppositional Problems. (Chronis, Eyberg, Greene, Kimhan, Nakamura, Ollendick, and Young, 2007). (Appendix E)

The National Alliance on Mental Illness (NAMI), the nation-wide education and advocacy organization of families and consumers, has also developed a family and consumer guide to evidence-based practices. Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices.[16] This easy to understand guide also describes many EBPs for children and adolescents. (Appendix F)

[14] (Burns, telephone interview, 2007)
[15] (Yannacci and Rivard, 2006).
[16] (Gruttadaro, Burns, Duckworth, and Crudo, 2007).

The Oregon Office of Mental Health and Addiction Services also lists those services and practices that meet their criteria for evidence-based and eligibility for funding.[17] This comprehensive site also provides a wealth of descriptive information regarding each approved service, including the population served, research evidence, service training materials available, and locations where the service may be provided (e.g. schools, clinics, home settings). (Appendix F)

In sifting through these and other lists of EBPs, several practices appear to be more widely embraced than others, either due to a significant body of research and implementation experience, a significant number of youth needing services, or both. Two of these EBPs appear to be Cognitive Behavioral Therapies (CBTs), with distinct components for depression, trauma, and anxiety disorders; and various parent management approaches typically involving support, education, and therapy. Due in large part to the work of the Dartmouth Trauma Intervention Research Center, trauma-focused CBT (TF CBT) is the most widely implemented approach within New Hampshire's public mental health system.

While it is not our purpose to describe each and every possible EBP and cite the research that supports their efficacy, some examples of EBPs include:

- Cognitive Behavioral Therapy (CBT) – for anxiety disorders
- Cognitive Behavioral Therapy (CBT) – for sexual abuse, other trauma
- Cognitive Behavioral Therapy (CBT) – for depression
- Exposure Therapy – Anxiety disorders
- Modeling Therapy – Anxiety disorders
- Multisystemic Therapy (MST)
- Multisystemic Family Therapy
- Multidimensional Treatment Foster Care (MDFT)
- Functional Family Therapy (FFT)
- Parent management Training
- Brief Strategic Family Therapy
- Treatment Foster Care
- Intensive Case Management (various models)
- Family Support and Training approaches (various models)
- Mentoring
- Mobile Response and Stabilization Services

Wraparound Approaches

Wraparound is a team-based approach to planning and coordinating formal and informal services and has broad family and community support as a way of organizing service delivery. This approach was widely promoted as a centerpiece for New Hampshire CASSP initiative and has received broad support, especially among families. Some lists of EBPs include wraparound as a "system-level" EBP; others do not include wraparound. But is it an evidence-based practice? One useful way to view wraparound may be as a platform for the

[17] (Oregon, 2007)

organization and delivery of services rather than as an evidence-based practice.[18] Weisz, et al., (2006) suggest that a useful way to approach wraparound is to bear in mind that while evidence-based services have strong scientific support they do not typically deal with the complexities of coordinating multiple interventions, and "in general [evidence-based services] have nothing like the kind of family and community acceptance achieved by systems of care and wraparound."[19] Thus they suggest combining evidence-based practices with wraparound or systems of care approaches:

> "Given that the contents of both systems of care and wraparound are free to vary with available services in the community, why not ensure that those specific services are, in fact, interventions that have been tested and shown to work? This might provide just the boost the community-based approaches need to generate beneficial effects that hold up well under scientific scrutiny. One approach could build on recent efforts at SAMHSA to encourage the use of evidence-based practices within community systems. Expanding this effort to encompass multiple empirically supported interventions, and to rigorously test program effectiveness with and without these interventions, could help to clarify whether the integration we propose carries the benefits we anticipate. It certainly seems fair to test a model in which the community-based strengths and potent delivery systems of wraparound and systems of care are united with the empirical strength of evidence-based interventions, to promote and protect mental health in children and their families." [20]

Evidence Based Practices in School Settings

Psychosocial EBPs in school settings are a significant development in the field of serving children and youth with mental health problems. Twenty years ago, mental health services for children and youth were provided in hospital, residential, and clinical settings. Today, the majority of mental health practices, models and supports are available in a variety of community-based settings.[21] One of the most important of these settings is the school. In fact, Burns et al. (1995) showed that 70-80% of all children who receive mental health services receive those services in school.[22] This may be a significant factor in determining how and where to implement EBPs.

The President's New Freedom Commission for Mental Health, in its 2003 report *Achieving the Promise: Transforming Mental Health Care in America*, found that schools "are in a key position to identify mental health problems early and to provide a link to appropriate services." The Commission recommended that school-based mental health programs be improved and expanded, using a 3-tiered public health model that includes prevention, early intervention, and intensive treatment and recovery-oriented services.

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[18] (Burns interview, 2007).
[19] Weisz, et al., (2006) (p. 644))
[20] Weisz, et al., (2006) (p. 645)
[21] (Ringeisen, Henderson, & Hoagwood, 2003).
[22] Burns et al. (1995)

The National Institute of Mental Health stresses the importance of a "real-world" context for the implementation of high-quality evidence-based practices in its 2001 report, *Blueprint for Change: Research on Child and Adolescent Mental Health*. Research has shown that a caring environment, consistency of implementation, high academic expectations, flexibility of services and academic programs, and developmentally appropriate services contribute to better school outcomes for all children, and yet the research on effective school-based mental health services is limited.[23] Experts in child and adolescent mental health advocate for the implementation of evidence-based mental health practices in schools, but only when there is a strong system of support and positive school culture.

Implementing Evidence-Based Practices

What is clear from the national literature regarding the implementation of innovation is the need for system-wide and local and/or organizational interventions. One clear factor associated with a successful implementation is the degree to which the various actors have reached consensus on adopting radically new approaches to services, as may be the case with implementing evidence-based services. As will be discussed later, there may not be consensus among the primary providers of mental health services to children in New Hampshire regarding EBPs. Some practical methods to begin the consensus-building process include statewide or regional conferences where clinicians, administrators, and families learn about EBPs from enthusiastic and successful practitioners.

Because the list of possible EBPs is growing, choosing among them can create inertia requiring some level of prioritization of effort. One national expert suggests simply narrowing the initial implementation list to a set of manageable choices.[24] In this regard, another national expert interviewed recommends an approach that focuses intervention where the service need is greatest in terms of child and adolescent problems that come to the attention of parents, schools and professionals. Trauma and disruptive behaviors appear to be among those problems that would meet these criteria.[25] The NH Department of Health and Human Services, in planning for evidence-based interventions to treat twenty youth currently in out-of-state residential placements, also adopts a strategy of implementing EBPs for those children and youth who present the greatest challenge in terms of behaviors and resource utilization.[26]

In addition to these broad strategic questions, there are a number of tactical steps that policy-makers can make which might facilitate the implementation of evidence-based practices. Spaniano and Herman (2005) for example, suggest that the following steps could significantly increase the changes of developing an evidence-based focus to the existing mental health system:[27]

(1) Increasing the demand for EBPs among key stakeholders including families
(2) Creating funding streams and regulations that support EBPs
(3) Providing the help of experts

[23] (Ringeisen, Henderson, & Hoagwood, 2003; Rones & Hoagwood, 2000)
[24] (Burns).
[25] Muesser (interview, 2007)
[26] (Jensen interview, 2007)
[27] Spaniano and Herman (2005, p. 252)

(4) Removing administrative barriers and creating incentives for EBPs
(5) Rigorous and consistent measurement of fidelity of the services
(6) Adopting clinical quality-improvement
(7) Continuously measuring clinical and family directed outcomes
(8) Supporting high quality research to discover what practices are evidence-based,
(9) Documenting effective EBPs.

At the organizational level, Fixsen, Naoom, Blasé, Friedman, and Wallace (2005) suggest that there are 5 core components of implementation which must be present in an organization in order for an implementation to succeed.[28] These 5 components and the findings are:

(1) Staff selection. The personal characteristics of staff that cannot be taught through training appear to be crucial.
(2) Pre-service and in-service training. Training itself is not sufficient to change provider behavior, but when combined with ongoing consultation, mentoring and coaching it is effective in producing the desired results.
(3) Ongoing consultation and coaching. While training introduces the staff to key approaches, ongoing consultation is necessary to produce long lasting changes, including training and mentoring of new staff.
(4) Staff and program evaluation. Measuring the extent to which the program maintains fidelity to its original interventions and the competency of staff in providing these interventions.
(5) Facilitative administrative support. The degree to which agency leadership provides support and focus to the effort.

Our interviews concurred with these assessments of the steps for a successful implementation. While necessary to a successful implementation, providing information on evidenced-based practices and training for staff is not a sufficient cause for a successful implementation. Instead, a long term approach addressing the need for consensus development, organizational development along the lines of the core components mentioned above is required. System-wide (i.e. statewide) factors may be more important for broad-scale implementation, but are perhaps less necessary for smaller-scale implementation at the program or single organization level.

An Example: Oregon

The single largest "top-down" policy initiative to implement evidence-based practices is in Oregon, where in 2003 the Oregon Office of Mental Health and Addiction Services (OMHAS) supported enabling legislation (SB267) requiring that any increased funding (excluding hospital and residential room and board) be used for evidence-based services. For 2005-07, the statute requires at least 25 percent of state funds be used to treat people with substance abuse problems who have a propensity to commit crimes be used for the provision of evidence-based practices. The statute also requires that 25 percent of state funds be used to treat people with mental illness who use or have a propensity to use emergency mental health services. In 2007-09, the percentage of funds to be spent on EBPs increases to 50 percent and in 2009-2011 to 75 percent.[29] Presently, Oregon has a list of approximately sixty

[28] Fixsen, Naoom, Blasé, Friedman, and Wallace (2005
[29] (Oregon OAMHAS, 2004)

services or interventions that are deemed sufficiently evidence-based to be eligible for funding.

In addition to changing the funding structure, OMHAS also provided additional supports at the system level and at the organizational level. OMHAS used this opportunity to work with stakeholders to incrementally restructure the mental health and substance abuse delivery systems for adults and youth, have various oversight committees with significant family and consumer representation, and have developed strong contract monitoring and compliance expectations and systems to oversee the development of evidence-based services. In addition, the Oregon Office of Mental Health and Addiction Services (OMHAS) offers extensive web resources for evidence-based practices. These resources include many fact sheets, reports, useful fidelity tools, and definitions of evidence-based practices recognized in Oregon for funding eligibility.[30]

Evidence-Based Practices in New Hampshire

We examined evidence-based practices in New Hampshire through interviews with a variety of different policy-makers. Clinical supervisors, state level and mental health agency administrators, child welfare administrators, and school system practitioners were interviewed, along with researchers and trainers in children's mental health, and family advocates for children and adolescents with serious emotional disorders. The team also conducted a brief open-ended survey of New Hampshire's ten community mental health center children's services directors to assess the extent of current implementation of evidence-based practices, interest in developing evidence-based practices, and their self-assessment of strengths and barriers to EBP introduction and implementation within their agencies and the statewide public mental health system.

Results point to increasing activity and support for evidence-based practice in New Hampshire. Moreover, this interest and activity is evident in a number of initiatives. Some are intended to address the "big picture" of statewide implementation of EBPs, while others are multi-regional efforts or local initiatives.

Results also indicate there is a high degree of anticipation and some tension around any movement toward evidence-based practices, particularly if these shifts require loss of "effective" practices (which some refer to as practice-based evidence) which may not have the research foundation required by EBPs but may meet gaps in services.

Additionally, several organizational infrastructures may be developing to support and advocate for the dissemination of EBPs, connect key stakeholders at the state and local levels, and address the administrative, funding, policy and legislative issues that are prerequisite to implementing and sustaining EBPs.

The following organizations or groups lead these public sector efforts:

[30] (Oregon OMHAS, 2007)

(1) Dartmouth Trauma Interventions Research Center (DTIRC) and the Dartmouth Psychiatric Research Center (PRC)
(2) NH Community Mental Health Centers
(2) The New Hampshire Center for Effective Behavior Interventions and Supports (NH CEBIS)
(3) NH DHHS Bureau of Behavioral Health Children's Individual Resiliency and Recovery Oriented Services/ Evidence Based Practices (IROS/EBP) Steering Committee
(4) New Hampshire Department of Health and Human Services Division of Children, Youth & Families Administrative Service Organization efforts
(5) Education and consumer advocacy efforts of the New Hampshire Chapter of the National Alliance on Mental Illness

The Dartmouth Trauma Intervention and Research Center (DTIRC)
The Dartmouth Psychiatric Research Center (PRC)

The Dartmouth Psychiatric Research Center was established in 1985 as a state-funded collaboration between Dartmouth Medical School and the NH Division of Mental Health and Developmental Services. The PRC is nationally recognized for its work in evidence-based practice for adults with severe mental illness (SMI) and has been a major developer of establishing six evidence-based practices for adults with SMI. PRC efforts led to six evidence-based practices: Assertive Community Treatment, Family Psychoeducation, Illness Management and Recovery, Integrated Dual Disorders Treatment, Medication Management, and Supported Employment. The Dartmouth Evidence-Based Practices Center (DEBPC) was founded in 2000 to facilitate the implementation of these EBPs in public mental health systems across the country.

More recently, a number of researchers currently at Dartmouth Medical School (Departments of Psychiatry and Community and Family Medicine) and Dartmouth College (Department of Psychology) have been at the forefront of efforts to better understand and treat post-traumatic disorders. Dartmouth investigators have worked to develop reliable efficient methods for assessment, to delineate the epidemiology of traumatic disorders (including cross-cultural studies), and to develop and test empirically supported treatments for Post-traumatic Stress Disorder (PTSD). More recent collaborations have been with DMS (Dartmouth Medical School) faculty on research involving changing systems of care to implement evidence-based practices for under-diagnosed and inadequately treated disorders, including common psychiatric disorders. In 2004, this group of researchers formalized their relationship by founding the Dartmouth Trauma Intervention and Research Center (DTIRC).

Utilizing a public health perspective, the goal of DTIRC is to translate evidence-based practices into a range of trauma-related interventions for under-served populations. A primary objective is to increase the availability and effectiveness of evidence-based mental health care for currently un-served or under-served trauma survivors across multiple healthcare settings, including youth who have been exposed to trauma.

In recent years, the PRC has worked under the leadership of the Dartmouth Trauma Interventions Research Center to begin to address treatment of children with severe

emotional disorders (SED). Most notably, the current work of Stanley Rosenberg, Ph.D. and Kim Mueser, Ph.D., has focused on the treatment of trauma in adolescents using Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice. In partnership with the West Central Services and the Bureau of Behavioral Health, the Dartmouth Trauma Interventions Center received a four year grant from the National Child Traumatic Stress Network (NCTSN). As a result, the New Hampshire Project for Adolescent Trauma Treatment (PATT) is implementing and evaluating best practices for trauma-exposed severely emotionally disturbed adolescents served by New Hampshire's community mental health system. The project is piloting trauma-focused cognitive-behavioral therapy (TF-CBT) and cognitive-behavioral intervention for trauma in schools (CBITS) through West Central Behavioral Health, which serves 500 to 600 adolescents each year, 95 percent of whom are classified with SED. The project is also working to establish TF-CBT as a routine evidence-based practice in New Hampshire's ten community mental health centers.

A recent grant award from the Endowment for Health will further this dissemination effort by supporting training and supervision throughout the ten mental health centers in NH, and the development of a tele-health video conferencing infrastructure to assure that all regions of the state have ongoing access to expert training, supervision and consultation to support implementation of TF-CBT. With a tele-health infrastructure in place, all mental health centers will be better able to access a broader range of expert training, supervision, and consultation for other EBPs, psychiatry, and other practices.

New Hampshire Community Mental Health Centers

New Hampshire's ten community mental health centers (CMHCs) provide state-supported services to adults with severe mental illness and children and adolescents with serious emotional disorders and are the primary provider of mental health services in the public system of mental health care. Largely funded through Medicaid fee-for-service funds and regulated by the New Hampshire Department of Heath and Human Services, the CMHCs are independent non-profit organizations working via contractual relationships with the State. Each CMHC provides services within a specified geographic region, from the urban centers of Nashua and Manchester to the most rural townships in the far reaches of the North Country.

As a part of this study, the children's services directors of each of the ten CMHCs were asked to briefly provide information regarding evidence-based practices in their agency and to assess the readiness of the state to implement and support evidence-based services. Eight of the ten agencies responded to our request for information.

In general, most were receptive to the concept of evidence-based practices and increasing EBPs within their agencies, identifying a variety of strengths that would support the development of EBPs. These strengths included agency and executive support for EBPs, experience in implementation of EBPs for adults, excellent collaborative relationships with other agencies, and teleconferencing capability for supervision and training.

Three primary concerns were raised, none of which are unique to New Hampshire, and appear to typify reactions heard elsewhere in the country.[31] The first related to EBPs themselves. A few CMHCs expressed skepticism regarding the ability of the system to support EBPs, questioning whether there was sufficient state-level commitment to funding and policy changes necessary to sustain new practices. Others were skeptical of EBPs themselves, questioning whether EBPs requiring manualized or "cookie-cutter" practices were of less value than the "practice-based evidence" services currently provided by highly qualified and trained clinicians.

The second was staffing. According to respondents, by far the most significant impediment to implementation of EBPs was in human resources, particularly sustainability of training and consultation to maintain practice fidelity. Rural agencies were burdened by the extensive travel and time away required to attend trainings, resulting in fewer staff participants. Too few "training of trainers" approaches have been implemented, making the task of retaining trained staff difficult to achieve given staff turnover. Because many EBPs require specialized and somewhat costly types of "manualized" training resulting in credentialed staff, these costs were difficult to cover. Some agencies cited the Division of Behavioral Health's significant decrease over the past decade in staffing a central training office and in funding and coordinating training as a significant barrier. The cost of training and on-going supervision for credentialing was seen as a problem. Lost revenue from clinicians spending time in training for EBPs was also seen as a barrier.

Finally, several respondents urged more emphasis on measuring client and family centered outcomes for "promising practices" as a place to better spend limited resources, as the cost and time involved in fidelity measurement, rigorous (and sometimes proprietary) practice protocols would not achieve a positive cost-benefit. Several agencies cited the importance – and cost – of developing outcome reporting for all services, not just EBPs, as a needed clinical tool to guide decision-making, and the lack of a system-wide clinical outcome measures system. The CMHCs now complete the Child and Adolescent Functional Assessment Scale, or CAFAS (Hodges, Xue & Wotring, 2004), to determine eligibility to meet Division of Behavioral Health certification criteria, but these data are not otherwise tabulated, reported, or used to guide clinical decision-making.

In what follows, we briefly describe the implementation of EBPs at the CMHCs that responded to the survey. Regions that are providing or planning to implement evidence-based practices are participants in the efforts led by the PATT Project utilizing additional resources. The telemedicine infrastructure used for training, supervision etc. was developed by Stan Rosenburg of the DTIRC and the CMHCs through a planning grant from the Endowment for Health and with additional foundation funds for the equipment. Individual CMHCs also brought financial and other resources as well as other grant funding to this initiative.

Region I: North Country. Licensed clinicians are in the process of receiving training in TF CBT. Clinical supervision with Dartmouth will begin pending enhancement of teleconferencing equipment. Use of practice will begin once that ongoing supervision is

[31] (Gruttadaro, telephone interview, 2007)(Burns, telephone interview, 2007).

scheduled. The North Country is also interested in implementing evidence-based practices for disruptive behaviors.

Region II: Hanover/Lebanon/Claremont area. West Central MH Services was an early adopter of TF-CBT, an EBP they have provided for the past two years. With Dartmouth Trauma Interventions Center support, West Central initially had six clinicians trained in this model and this past winter trained all of their remaining child clinicians. The agency has weekly group supervision for this model with the original six clinicians. Based on this experience the agency hopes to implement additional evidenced-based practices with support from Dartmouth. They view children and adolescents with disruptive behavior disorders as a primary need, and would also like to explore treatment options for younger children.

Region III Laconia Area – Genesis Behavioral Health. This region began providing TF-CBT in October 2006, with training and on-going consultation provided through Dartmouth with funding from a Victims Of Crime Act (VOCA) Grant. The agency also administers substance abuse assessments using the Global Assessment of Individual Needs (GAIN) which staff has been certified to administer. The agency's priority moving forward is evidenced practice for young children who have experienced trauma, and hope to begin work to adapt TF-CBT with a local Head Start program.

Region IV – Central NH/Concord Area. Riverbend Community Mental Health. Riverbend CMH is in the process of beginning TF-CBT. They have many staff members that are trained in CBT treatment, although they may not be using a "manualized" approach.

Region V – Monadnock Family Services (MFS) - Keene/Peterborough. This region has begun training for three Children's Services staff in the Trauma Focused CBT model through Dartmouth and has had an Adolescent Dialectical Behavior Therapy (DBT) program for five or six years. Additionally, the agency's Baby Time program uses the "Parents as Teachers" (PAT) curriculum.

The agency has assessed its needs and priorities, as well as informally gauged the local community's priorities for strong services to a challenging population and determined that youth with Disruptive Behavior Disorders are a priority population for EBP development. Toward this end, the agency has done some preliminary research on possible programs and models that have some evidence base (i.e. The Incredible Years, Nurturing Parent), but has not secured funding enough to move ahead with these initiatives. Monadnock Family Services has also applied for a grant for programming that would use the Parenting Wisely curriculum. Lastly, some clinicians are using Scott Miller and Barry Duncan's Client Directed Outcome Informed Treatment with a portion of their caseloads. Clinicians are also using Motivational Interviewing with clients to assist in engagement and moving persons through stages of change.

Region VI – Greater Nashua. The Community Council of Great Nashua intends to launch TF-CBT this summer.

Region VIII: Dover/Rochester area. This CMHC has started to utilize one evidence-based practice – TF-CBT for children starting in mid-July, 2007.

Region IX: Portsmouth/Exeter area. Seacoast Mental Health is not yet providing any EBPs but is working toward implementing TF-CBT. The agency is also looking at some EBP models for substance abusing youth. At one point clinical staff were interested in using multidimensional family therapy for substance abusing youth but did not receive the funding that would support training and supervision.

The Children's IROS/EBP Steering Committee

Under the auspices of the State Bureau of Behavioral Health's Office of Children's Services, the IROS/EBP Team has as its mission to guide practice and policy decisions to improve children's community mental health services. In addition to the Bureau of Behavioral Health Children's Administrator, the team includes all of the 10 community mental health children's directors, the Granite State Federation of Families, NAMI-NH, the Division of Children, Youth and Families, Casey Family Services, and the Dartmouth PRC. It is hoped that the PRCs participation will help to integrate evidence-based practices into state-level regulations and reimbursement mechanisms to sustain and expand services.

The IROS/EBP Team has been researching the various EBPs and implementation processes in other states. The Children's IROS/EBP team, as a subgroup of the Bureau of Behavioral Health EBP Steering Committee, may offer important links among the experts, researchers, implementers at the local level, and state level policy makers in order to create policy and reimbursement mechanisms that support high quality EBP service delivery, expand EBP accessibility, and other enhancements of EBPs.

The IROS/EBP Committee is also addressing the workforce development issues, and has informed the Bureau of Behavioral Health's development of Foundation Skills Training for all mental health direct service staff members. Foundation Skills Training consists of a series of training modules, provided to CMHC staff, including Introduction to Mental Health (Mental Health 101), Stages of Change, Cognitive Behavior Therapy, Working With Families and Motivational Interviewing. All of the training modules have been developed and are being provided to CMHC staff.

The IROS/EBP Committee has also identified priority areas for further EBP dissemination, using CBT as a platform for treatment, including adapting CBT for Disruptive Behavior Disorders, Mood Disorders and Anxiety Disorders. As with the trauma focused work currently underway, Dartmouth will develop the treatment protocols, provide training, and measure practice fidelity.

The New Hampshire Department of Health and Human Services, Division of Children, Youth and Families (DCYF) and Division of Community Based Care Services

The NH Department of Health and Human Services' DCYF/DJJS provides foster care and residential placement services to over 1,400 children/youth annually, through court intervention for abuse, neglect, delinquency or CHINS (child in need of services) petitions.

Among the several levels of foster care provided, therapeutic foster care most closely approximates the evidenced-based practice of Treatment Foster Care. However, this service is not delivered with exact fidelity to an EBP model. Interviews with DHHS staff indicate that the agency hopes to integrate services for high-need, multi-agency children/youth via an Administrative Service Organization (ASO). This project is led by Mr. Egon Jensen of the Division of Community Based Care Services. The initial population of children/youth to be served are those who have been receiving intensive level residential services, both in- and out-of- state, for over 12 months. This population is generally the agency's most challenging in terms of behaviors, need for treatment and resource utilization.

Although currently in the initial planning stages, the agency hopes to pilot a single portal of access, combined with braided funding, to serve this population of high need, multi-agency children/youth and their families. While the costs associated with treating this population are high, the goal of the effort is to provide services that result in better outcomes for them, not merely to save funds. Research indicates that home and community-based services are able to result in better outcomes than long-term intensive level residential placement. This effort utilizes both the CASSP "systems of care" concept and elements of the wraparound model. In particular, the use of braided funding to pay for intensive services may provide an opportunity to develop and sustain EBPs in DCYF/DJJS, DCBCS, OMBP and the Department of Education to better meet the needs of high-need, multi-agency children/youth.

The New Hampshire Center for Effective Behavioral Interventions and Supports (NH- CEBIS)

In 2002, the New Hampshire Department of Education (DOE) provided significant funding to establish the NH-Center for Effective Behavioral Interventions and Supports (NH-CEBIS) at the Southeast Regional Special Education Collaborative (SERESC) and Rivier College. Since its inception, NH-CEBIS has enrolled and provided training and technical support to 5 school cohorts, comprising a total of 140 pre-schools, elementary, middle and high schools to implement school wide and individualized services to children using Positive Behavioral Interventions and Supports (PBIS). [32] Through its 3-tiered model of intervention and

[32] Positive Behavioral Interventions and Supports (PBIS) is defined as a "comprehensive approach" to school discipline through the creation of a 3-tiered system of behavioral interventions fashioned after the public health intervention model that includes universal, secondary and tertiary intervention based upon the levels of impairment and need of the targeted population. According to Sugai et al. (1999), "PBIS implementations consider multiple contexts… a proactive (and positive and preventative) perspective is maintained along three levels: (a) primary: reducing the number of new cases of problem behavior, (b) secondary: reducing the number of current cases of problem behavior, and (c) tertiary: reducing the intensity and complexity of current cases" (p. 10-11). Muscott and Mann (2003) define PBIS as "a sustainable, proactive process that improves social, behavioral, and academic outcomes through positive, preventive evidence-based strategies, collegial and collaborative teaming, and data-based decision-making." At the tertiary level, PBIS services include intensive, individualized services for children and adolescents who have significant impairments related to emotional or behavioral disorders or mental illnesses (Eber, Nelson, & Miles 1997; Bohanon, Fenning, Eber & Flannery, 2007). PBIS researchers assert that the approach must include "a set of evidence-based strategies that can be implemented in schools" (Bohanon, et al., 2007, p. 1).

supports, PBIS implementation serves as a structure for the early identification and implementation of effective interventions, and of referral to mental health services.

At the same time that CEBIS was established, the New Hampshire Department of Education began to implement a federally funded dropout prevention project, APEX (Achievement In Dropout Prevention and Excellence), that uses PBIS as the model to address school wide discipline issues and individual student disengagement from high school. The APEX project employs an intensive, school-to-career intervention for adolescents with emotional and behavioral disorders that was developed in New Hampshire in 1996, called RENEW (Rehabilitation for Empowerment, Natural supports, Education and Work). RENEW is not an evidence-based practice but has accumulated positive outcomes for over 500 students.[33] The APEX initiative is a collaboration between the state DOE, the Institute on Disability at UNH, and the Alliance for Community Supports. APEX staff works closely with CEBIS to provide school wide PBIS support and training for 10 high schools in New Hampshire.

The CEBIS team is just beginning to train schools to adopt a practice that has positive evidence using single-subject research designs. This model, Check-In and Check-Out[34] could be considered a Level 4 practice as a similar model, Check and Connect[35], has been shown effective using randomized clinical trails, but has not yet been replicated. Check and Connect is being introduced to New Hampshire high schools in 2007 through the APEX II project. The research team did not conduct a survey of schools, however, to identify in any systematic way the extent of EBP implementation within the schools.

More recently, as a result of the partnership and commitment to collaboration between NH CEBIS, the NH DOE, the NH Bureau of Behavioral Health, and APEX, CEBIS, in partnership with the Londonderry School District, has received a U.S. Department of Education, Office of Safe and Drug Free Schools grant to link school and mental health services. This project, entitled Mental Health and Schools Together-NH (MAST-NH) initiative creates a statewide infrastructure for training and collaboration between PBIS-NH schools, parents, mental health and community-based organizations. MAST is designed to increase and enhance access to appropriate mental health services to children and youth with the most significant needs in eight demonstration communities. Priorities of the initiative include increasing students' access to (a) trained wraparound facilitators who can guide the creation and implementation of wraparound plans, (b) school and mental health personnel who can de-escalate escalating and unsafe student behavior, and (c) community collaboratives engaged in the creation of action plans to address gaps in services revealed from a community resource mapping process. The partners involved in MAST-NH are working to create effective, community-based infrastructures for the early identification, assessment, and provision of mental health services to children and youth.

[33] (Bullis & Cheney, 1999; Hagner, D., Cheney, D., Malloy, J., 1999; Malloy & Cormier, 2004)
[34] (Hawkin, Macleod, & Rawlings, 2007)
[35] (Sinclair, Christenson, & Thurlow, 2005)

The New Hampshire Chapter of National Alliance on Mental Illness (NAMI NH)

NAMI New Hampshire is a statewide advocacy, support, and educational organization for persons of all ages with serious mental illness and their families. For more than thirty years, NAMI NH has played a central role in system monitoring, advocacy for improvements in services and adequate funding, and providing family education and family-to-family support through a statewide network of trained local affiliates.

With a highly qualified staff, active Board of Directors, and many committed family and consumer volunteers, NAMI NH plans to educate families of children and adolescents about evidence-based practices, using NAMI's recent publication Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices.[36] NAMI NH supports the expansion of evidence-based practices and views its role as educating families to expect appropriate services and to ask if the care they are receiving has any empirical basis.[37]

Final Notes

Many interviewees indicated that there is a need to educate top level policy makers, legislative leadership, families, and consumers in order to build the demand for EBPs. This might mean convening state and national experts in EBPs to build enthusiasm and support, and to support family groups to educate their members. Additionally, the initiatives of the Dartmouth Centers provide significant resources in the New Hampshire efforts. Many of those interviewed recommended the need for training, data collection, and other non-direct service related tasks required for EBP implementation.

Another finding is that the work of many of the individual Community Mental Health Centers, that have proven resourceful in obtaining small seed grants to develop EBPs, including working within schools and other non office-based locations, indicates the interest among mental health professionals to use EBPs in their practice with children. There may be ways to support the local efforts of early adopters as state models. The school-based work of the Center for Effective Behavioral Interventions and Supports (CEBIS) stands out as another potential "point of entry" for the implementation of EBPs.

Given that there is interest in EBP implementation, and several resources and structures for development of EBPs in New Hampshire, there is the potential to engage state and national experts to assist in ongoing strategic planning and developing guidelines for decision-making.

Lastly, we suggest that the general implementation strategies,[38] discussed earlier in this report, can be a useful guide for consideration of direct and indirect approaches to the expansion of EBP implementation. They are:

[36] (Gruttadaro et. al. 2007).
[37] (Cohen, Ferber interview, July 2007).
[38] (Spaniano & Herman, 2005)

(1) Increase the demand for EBPs among key stakeholders.
(2) Create funding streams and regulations that support EBPs.
(3) Provide the help of experts.
(4) Remove administrative barriers and create incentives for EBPs.
(5) Ensure rigorous and consistent measurement of fidelity of the services.
(6) Adopt clinical quality-improvement.
(7) Continuously measure clinical and family directed outcomes.

Conclusion

The research shows that EBPs work across diverse populations, including persons in low-income families, and families of color. There are also an ever-expanding number of practices that are evidence-based, not just a few practices meant for a few children. The interviews with stakeholders indicated a general support for EBPs. The interviews also identified significant resources to build on, including the Dartmouth efforts and work that is taking place to implement EBPs in selected community mental health centers. Specific statewide programmatic efforts that show promise include the NH Administrative Service Organization (ASO) pilot project with the Division of Community Based Care Services and the Children's IROS/EBP team within the Bureau of Behavioral Health.

Despite these strengths, a number of concerns were expressed by interviewees. Nearly all the community mental health centers, the family advocates, and other interviewees expressed concern that, unless mechanisms were established to maintain training, consultation, and to address reimbursement policies allowing for reimbursement of EBP activities, EBPs are not sustainable. In addition, according to respondents by far the most significant impediment to implementation of EBPs was in human resources, particularly sustainability of training and consultation to maintain practice fidelity.

For the system as a whole, there are both system-wide and organizational supports that would be necessary to support the expansion of EBPs. At the system level, the keys for a successful and ongoing implementation of an EBP-focused system include consensus development on the direction the system is heading. At the organizational level, providing organizations with EBP expertise, sufficient training opportunities for staff, and creating funding and regulations that support EBPs are critical.

There are various approaches that states can take to provide leadership for EBP implementation. At one end of the spectrum is Oregon, where state legislation and a careful buy-in process (including soliciting a list of EBPs from provider agencies) now mandate EBPs and specifically ties these evidence-based services to reimbursements. Oregon's process has been facilitated with substantial funds from a Real Choice Systems Change grant. Other states have decided to begin implementing EBPs for certain populations or to implement for only a limited set of practices. New Hampshire falls at this end of the spectrum. In the area of adult services, the efforts of the Dartmouth PRC have thus far been the major driver of this change in New Hampshire and the efforts of the Dartmouth Trauma Intervention and Research Center have begun the essential work of bringing EBPs to

children's services. On the policy side, the NH state rules for state/federally-supported mental health services identify evidence-based practices as important but pose a challenge for agencies, however, because there is not reimbursement for activities such as training, supervision and other activities associated with the implementation of EBPs.

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APPENDIX A
Evidence-Based Practice Inquiry
Interviews and Surveys
May- July, 2007

Individual or Agency	**Date Interviewed**
Joe Perry, Administrator of Children's Services, NH Bureau of Behavioral Health	May 25, 2007
Joe Perry (2)	June 8,2007
Joe Perry (3)	July 9,2007
Howard Muscott, Ed.D., Eric Mann, MSW, Co-Directors, NH CEBIS	May 23, 2007
Kim Meuser, Ph.D. & Stan Rosenberg, Ph.D., Dartmouth Psychiatric Research Center	May 30, 2007
Egon Jenson, NH Division of Community Based Care Services	June 26, 2007
Ken Jue, CEO, Carol Jue, Children's Services, & Doug Iosue, Monadnock Family Services, Children's Director	June 29, 2007
Louis Josephson, President, CEO, Riverbend Community Mental Health Center, Concord Region	July 6, 2007
Deb Grabill, Consultant, NH, Department of Education	June 8, 2007
Melissa Mandrell, Board Chairperson, Granite State Federation of Families for Children's Mental Health	June 8, 2007
Kathleen Abate, Linda Thomas, (Federation of Families)	June 5, 2007
Mike Cohen, Executive Director, and Claudia Ferber, Children's Coordinator, NH-NAMI	June 13, 2007
Barbara Burns, Ph.D., Professor of Medical Psychology in the Department of Psychiatry and Behavioral Sciences at Duke University School of Medicine	June 27, 2007
Ray Barrett, Genesis Lakes Region Community Mental Health Center, Director of Children's Services	July 19, 2007
Schools (MAST group) -Linda Potter, Con Val School District -Kevin Murphy, Director, Strafford Learning Center	June 30 and July 6, 2007
Surveys-10 CMHC Children's Directors	June 24 - July 10, 2007
Nancy Rollins, Director, Community Based Care Services, NH Department of Health and Human Services	June 13, 2007
David Osher, Ph.D., Managing Director at AIR (American Institutes for Research), Washington, D. C.	June 13, 2007
Darcy Gruttadaro, National Alliance on Mental Illness Washington, D. C.	June 12, 2007

APPENDIX B

Dear Children's Services Director,

Thanks for taking a few minutes to reply to this e-mail. Except for areas where you may be already doing evidence-based services or are in the process of implementing them (this is newsworthy!), we are mostly looking for common themes regarding the pros and cons of all of the attention paid to evidence-based practices and will not be directly quoting your opinions.

Background:
The NH Center for Public Policy Studies is examining evidence-based practices in child and adolescent mental health for the Endowment for Health. This evaluation will help the Endowment for Health decide on initiatives beginning in the fall of 2007. The assessment includes a brief review of the literature, an inventory of evidence-based and best practices used in New Hampshire's schools, child serving agencies including the community mental health centers, and interviews with key staff and administrators. We are trying to identify both opportunities and barriers to implementation to help the Endowment make informed choices for investing their resources going forward.

For this survey, evidence-based practices are based on scientific evidence by *multiple randomized controlled studies or sometimes with less rigorous types of research*. In *all cases* the service is standardized and documented to allow both replication and measurement of fidelity with a fidelity tool that defines the essential elements of the practice.
This is different from "promising practices" in which the treatment, service, or practice is not yet sufficiently documented or replicated through scientifically rigorous research. However, the practice may be building strong evidence through documentation of procedures and outcomes, and it fills an important gap in the services. The practice is not standardized enough to develop a fidelity tool.

With these definitions in mind:

1. Briefly describe any evidenced-based services your agency is providing to children and youth. Any evidence-based services planned? Any that would be more essential or important to do first?
2. What organizational structures are in place in your agency that would support developing evidence-based practices?
3. Your agency most certainly provides "promising practices" that have not reached the threshold for "evidence-based" but address essential gaps in services. What are these essential services?
4. In your estimation what are the agency or statewide barriers to implementing evidence-based services? What are possible solutions?
5. Continuing evidence-based services once they begin requires continued training, supervision, data collection and monitoring of fidelity. What would your agency require in order to maintain evidence-based services once they were established?

APPENDIX C

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\..\Projects\Mental Health\Children\DRAFTS - Publications\Childrens EBP interventions matrix.pdf

APPENDIX D

http://www.wjh.harvard.edu/~nock/Div53/EST/index_files/Page624.htm

Evidence-Based Treatment for Children and Adolescents

Evidence-Based Treatments Home • Anxiety • Depression • ADHD • Conduct Problems • SCCAP

Definitions of Evidence Based Approaches

Best Support ("Well-Established Treatments")

I. At least two good between group design experiments demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group; cf. Kazdin & Bass, 1989).

OR

II. A large series of single case design experiments ($n \geq 9$) demonstrating efficacy. These experiments must have:
   a. Used good experimental designs
   b. Compared the intervention to another treatment as in I.a.

AND

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.
IV. Characteristics of the client samples must be clearly specified.
V. Effects must have been demonstrated by at least two different investigators or teams of investigators.

Promising ("Probably Efficacious Treatments")

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group. *Manuals, specification of sample, and independent investigators are not required.*

OR

II. One between group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group; cf. Kazdin & Bass, 1989).

OR

III. A small series of single case design experiments ($n \geq 3$) with clear specification of group, use of manuals, good experimental designs, and compared the intervention to pill or psychological placebo or to another treatment.

Evidence-Based Treatment for Children and Adolescents

Society of Clinical Child and Adolescent Psychology

Division 53, American Psychological Association

& the Network on Youth Mental Health

Funded by the John D. and Catherine T. MacArthur Foundation

What is this site about

The purpose of this site is to inform the general public as well as practitioners regarding the most up-to-date information about mental health practice for children and adolescents. While there are many approaches for treating various psychological disorders, the treatments listed here have been evaluated scientifically for efficacy and will be updated as new treatment research is completed.

Categories of Disorders

- Anxiety Disorders
- Depression (Dysthymia)
- Attention Deficit Hyperactivity Disorder (ADHD)

Society of Clinical Child and Adolescent Psychology Committee on Evidence-Based Practice

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Kristin Hawley, Ph.D.
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APPENDIX E

NAMI

National Alliance on Mental Illness

Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices

NAMI is the National Alliance on Mental Illness, the largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. A nationwide organization founded in 1979, NAMI has become the nation's voice on mental illness, with affiliates in every state and in more than 1,100 local communities across the country.

NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all who are affected by these diseases.

National Alliance on Mental Illness
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042

Web site: www.nami.org
Telephone: (703) 524-7600 or (800) 950-NAMI (6264)

Child & Adolescent Mental Health Treatments

Diagnosis	*Evidence-Based Psychosocial Interventions*	**Psychopharmacology*
Anxiety	Ages 9–18 • Cognitive Behavioral Therapy (CBT) Ages 3–17 • Exposure Therapy Ages 3–13 • Modeling Therapy	**Antidepressant medication (Selective Serotonin Reuptake Inhibitors—SSRIs); Benzodiazepines (no controlled evidence, but used in clinical practice).
Attention Deficit Hyperactivity Disorder (ADHD)	Ages 3–12 • Behavior Therapy (in home and in school) Ages 3–16 • Parent Management Training The combination of behavior therapy and medication is often most effective in treating ADHD.	Stimulant and non-stimulant (Strattera) medications. (FDA requires a patient medication guide alerting consumers of possible serious side effects.)
Autism	Ages 3–13 • Behavior Therapy Ages 3–13 • Individual and family therapies that target communication skills, interaction skills, and behavior modification.	Antipsychotic medication has been shown to reduce aggression.
Bipolar Disorder	No controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Mood stabilizers (Lithium and Valproate—an anti-convulsant medication); Atypical antipsychotic medication; and other medications may be appropriate.
Conduct Disorder/Oppositional Defiant Disorder (CD/ODD)	Ages 3–15 • Parent Training (multiple EBPs for different age groups) Ages 9–15 • Anger Coping Therapy (targets skill development in school) Ages 6–17 • Brief Strategic Family Therapy (BSFT) Ages 13–16 • Functional Family Therapy (FFT) Ages 9–18 • Treatment Foster Care (TFC) Ages 12–17 • Multisystemic Therapy (MST) Ages 12–17 • Mentoring Ages 9–18 • CBT	Antipsychotic medication & mood stabilizers. (CD and ODD often co-occur with other mental illnesses so other medications may be appropriate.)
Depression	Ages 9–18 • CBT Ages 11–18 • Relaxation Therapy Ages 12–18 • Interpersonal Therapy (IPT) Ages 12–18 • Family Education and Support The combination of CBT and medication is often most effective in treating major depression.	**Antidepressant medication (SSRIs)
Schizophrenia	No controlled studies of psychosocial interventions for youth with schizophrenia have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Antipsychotic medication

Information in the chart is based on reviews by Burns, Chorpita, Chambless and Halloran, Hoagwood, Jensen, Weisz, and the authors of the Guide.

* Generally, there is limited research on children's medication use, but more research exists on the utilization of ADHD medication.

** The Food and Drug Administration (FDA) has issued a "black box" warning about the increased risk of suicidal thoughts and behaviors in youth being treated with antidepressant medications.

APPENDIX F

FROM http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml

AMH practices - approved and under review

Complete list of OMHAS approved practices
Practices currently under review
OMHAS approved practices by discipline and population

We are in the process of updating or revamping this Web page. Please contact one of the following fidelity committee members if you have questions on a specific practice.

Substance Abuse: Diane Lia, (503) 945-6197
Prevention: Rey Agullana, (503) 945-6998
Mental Health: Mike Moore, (503) 947-5538
Children's Mental Health: Matt Pearl, (503) 947-5524
Research: Dagan Wright, (503) 945-5726
Applications and Review Process: Greta Coe, (503) 945-6187
Definition and Implementation: Shawn Clark, (503) 945-9720

********This page was last modified on Aug. 1, 2007.*

Addiction and Mental Health Services (AMH) established this list as an informational tool for providers to use in the selection and implementation of Evidence-Based Practices. AMH does not assert that this list represents a comprehensive compilation of all Evidence-Based Practices (EBPs). There may be many practices or programs not yet reviewed by OMHAS that would meet the AMH definition for EBPs.

Some practices have been reviewed and have been found not to meet the AMH definition of an Evidence-Based Practice. By not adding these practices to the EBP list, AMH does not maintain that the practices are ineffective, only that rigorous scientific evidence for effectiveness is lacking.

OMHAS Approved Practices

12-step Facilitation
Across Ages
Al's Pals: Kids Making Healthy Choices
All Stars
American Indian Life Skills Development (PDF)
Applied Suicide Intervention Skills Training (ASIST)
ATLAS (Athletes Training and Learning to Avoid Steroids)
ASAM
Assertive Community Treatment (PDF)
BASICS: Brief Alcohol Screening and Interventions for College Students (PDF)
Behavioral Couples (Marital) Therapy
Behavioral Therapy for Adolescents
Behavioral Therapy/Nicotine Replacement Therapy
Big Brothers/Big Sisters of America (PDF)
Border Binge-Drinking Reduction Program
Brief Strategic Family Therapy (BSFT)
Buprenorphine
California Smoker's Helpline (PDF)
Cannabis Youth Treatment
CASA START
CBT - Childhood Anxiety Disorder (PDF)
CBT - Depression in Adolescents (No link available)
CBT - Project Match
CBT - Trauma Focused (PDF)
Challenging College Alcohol Abuse

Child Development Project (CDP)
Children in the Middle
Children of Divorce Intervention Program (CODIP) (PDF)
Class Action
Cognitive Behavioral Therapy for Substance Abuse
Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA) (PDF)
Cognitive Behavioral Therapy for Schizophrenia and Other Psychotic Disorders (PDF)
Cognitive Retraining/Remediation/Rehabilitation
Commit to Quit (PDF)
Communities Mobilizing for Change on Alcohol (CMCA)
Community Reinforcement Approach (CRA) with Vouchers
Community Trials Intervention to Reduce High-Risk Drinking (RHRD) (PDF)
Communities That Care
Consumer Run Drop-in Centers (PDF)
Contingency Management (w/o community reinforcement)
Co-Occurring Disorders: Integrated Dual Diagnosis Disorders
Coping Power
Coping with Work and Family Stress (PDF)
Creating Lasting Family Connections (CLFC)
DARE to Be You (DTBY)
DBT Substance Abuse
DBT Adolescents (PDF)
Dialectical Behavioral Therapy for Adults (DBT)
Drug Court, Treatment Court, MH Court, Family Court
Early Risers: Skills for Success
EAST
East Texas Experimental Learning Center (PDF)
Enough Snuff (PDF)
Eye Movement Desensitization and Preprocess (EMDR) (PDF)
Families and Schools Together (FAST)
Families That Care: Guiding Good Choices (GGC) (PDF)
Family Advocacy Network Club (FAN)
Family Development Research Project (PDF)
Family Effectiveness Training (FET)
Family Matters
Family Pyschoeducation (PDF)
First Steps to Success (Link available)
Friendly PEERsuasion
Functional Family Therapy
Global Appraisal of Individual Needs
Good Behavior Game
Greater Access to EAPS (GATE) (PDF)
Healthy Workplace (PDF)
Helping the Non-Compliant Child
High-Scope Perry Preschool Program (PDF)
Home-Based Behavioral Systems Family Therapy
Houston Parent-Child Development Program
Illness Management and Recovery (PDF)
Impact of Drinking Age Law (PDF)
Improving Mood Promoting Access to Collaborative Treatment (IMPACT) (PDF)
Incredible Years
Individual Drug Counseling
Individual Placement and Support (PDF)
JOBS Program (PDF)
Keep a Clear Mind (KACM)
Keepin' IT REAL
Kentucky Adolescent Tobacco Prevention Project (PDF)
Leadership and Resiliency Program (LRP)
Legal Blood Alcohol Level (effects of Maine's .05% limit) (PDF)
Life Skills (Botvin)
Lions-Quest Skills for Adolescence
Matrix Model

Medication Management (link unavailable)
Message Framing (PDF)
Motivational Enhancement Therapy (MET)
Motivational Interviewing
Multidimensional Family Therapy (PDF)
Multidimensional Treatment Foster Care
Multisystemic Family Therapy
Music Therapy- Dementia and Geriatrics
Non-violent Crisis Intervention Training Program
Not on Tobacco (PDF)
Nurse-Family Partnership Program
Olweus Bullying Prevention (PDF)
OSLC Treatment Foster Care (PDF)
Outpatient Treatment with Synthetic Opioid Replacement Therapy (Methadone)
Parent-Child Interaction Therapy
Parenting Wisely
Parent Management Training (PDF)
Partnership for Health (PDF)
PATHS: Promoting Alternative Thinking Strategies (PDF)
Pathways to Change
Physicians Counseling Smokers (PDF)
Positive Action (PA)
Prepare/Enrich Program (No link available)
Project ACHIEVE
Project ALERT
Project EX
Project Northland
Project STAR: Students Taught Awareness and Resistance
Project SUCCESS
Project Toward No Drug Abuse (TND)
Projects Toward No Tobacco Use (TNT)
Project Venture (PDF)
Prolonged Exposure Therapy for Posttraumatic Stress (PDF)
Protecting You/Protecting Me
Reconnecting Youth (RY)
Relapse Prevention
Residential Student Assistance Program (RSAP)
Resolving Conflict Creatively Program (RCCP) (PDF)
Responding in Peaceful and Positive Ways - RiPP
Rural Educational Achievement Project (PDF)
SAFE Children: Schools and Families Educating Children
Safe Dates
School Violence Prevention Demonstration Program (PDF)
Second Step
Seeking Safety
Sembrando Salud
Skills, Opportunities and Recognition (SOAR)
SMART Leaders
SMART Team: Students Managing Anger and Resolution Together Team
Smoking Prevention Mass Media Intervention (PDF)
Social Competence Promotion Program for Young Adolescents (SCPP-YA)
Solution-Focused Brief Therapy (PDF)
Start Taking Alcohol Risks Seriously (STARS) for Families
Stopping Teenage Addiction to Tobacco (STAT)
Strengthening Families Program (SFP)
Strengthening Families Program: For Parent and Youth 10-14
Strengths Model of Case Management
Supported Education
Supported Employment (PDF)
Supported Housing (Link unavailable)
Support for at-Risk Children (PDF)

Teaching Students to Be Peacemakers (PDF)
Team Awareness (for the Workplace) (PDF)
Therapeutic Communities
Tobacco Policy and Prevention (TPP) (PDF)
Too Good for Drugs (TGFD) (PDF)
Too Good for Violence (PDF)
Wellness Outreach at Work (PDF)
Wraparound

OMHAS Practices Currently Under Review

Acceptance and Commitment Therapy
Collaborative Problem Solving
NIATx
Oxford Houses

OMHAS approved practices by discipline and population

- **Mental Health**
  - Applied Suicide Intervention Skills Training (ASIST)
  - Assertive Community Treatment (PDF)
  - Brief Strategic Family Therapy (BSFT)
  - CBT - Childhood Anxiety Disorder (PDF)
  - CBT - Depression in Adolescents (No link available)
  - CBT - Trauma Focused (PDF)
  - Consumer Run Drop-in Centers (PDF)
  - Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA) (PDF)
  - Cognitive Behavioral Therapy for Schizophrenia and Other Psychotic Disorders(PDF)
  - Cognitive Retraining/Remediation/Rehabilitation
  - Co-Occurring Disorders: Integrated Dual Diagnosis Disorders
  - DBT Adolescents (PDF)
  - DBT Substance Abuse
  - Dialectical Behavioral Therapy for Adults (DBT)
  - Drug Court, Treatment Court, MH Court, Family Court
  - EAST
  - Eye Movement Desensitization and Preprocess (EMDR) (PDF)
  - Family Pyschoeducation (PDF)
  - Functional Family Therapy
  - Illness Management and Recovery (PDF)
  - Improving Mood Promoting Access to Collaborative Treatment (IMPACT) (PDF)
  - Incredible Years (PDF)
  - Medication Management (link unavailable)
  - Multidimensional Family Therapy (PDF)
  - Multidimensional Treatment Foster Care
  - Multisystemic Family Therapy
  - Music Therapy- Dementia and Geriatrics
  - Non-violent Crisis Intervention Training Program
  - Parent-Child Interaction Therapy
  - Parent Management Training (PDF)
  - Prepare/Enrich Program (no link available)
  - Prolonged Exposure Therapy for Posttraumatic Stress (PDF)
  - Seeking Safety
  - Solution-Focused Brief Therapy (PDF)
  - Strengths Model of Case Management
  - Supported Education
  - Supported Employment (PDF)
  - Supported Housing (Link unavailable)
  - Trauma Focused CBT (PDF)
  - Wraparound
- **Substance Abuse**
  - 12-step Facilitation (PDF)
  - ASAM
  - Behavioral Couples (Marital) Therapy
  - Behavioral Therapy for Adolescents
  - Behavioral Therapy/Nicotine Replacement Therapy

- Brief Strategic Family Therapy (BSFT)
- Buprenorphine
- Cannabis Youth Treatment
- CBT - Depression in Adolescents (No link available)
- CBT - Project Match
- CBT - Trauma Focused (PDF)
- Community Reinforcement Approach (CRA) with Vouchers
- Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA) (PDF)
- Cognitive Behavioral Therapy for Substance Abuse
- Contingency Management (w/o community reinforcement)
- Co-Occurring Disorders: Integrated Dual Diagnosis Disorders
- DBT Substance Abuse
- Drug Court, Treatment Court, MH Court, Family Court
- Functional Family Therapy
- Global Appraisal of Individual Needs
- Individual Drug Counseling
- Matrix Model
- Medication Management (Link unavailable)
- Motivational Enhancement Therapy (MET)
- Motivational Interviewing
- Multidimensional Family Therapy (PDF)
- Multidimensional Treatment Foster Care
- Multisystemic Family Therapy
- Outpatient Treatment with Synthetic Opioid Replacement Therapy (Methadone)
- Relapse Prevention
- Seeking Safety
- Supported Housing (Link unavailable)
- Wraparound